Abstract. In this essay, some of the signatories to “Medical Intervention in Cases of Maternal–Fetal Vital Conflicts: A Statement of Consensus” respond to “The Placenta as an Organ of the Fetus: A Response to the Statement of Consensus on Maternal–Fetal Conflict,” both recently published in this journal. The response examines Bringman and Shabanowitz’s claims and assumptions about the morally relevant pathologic condition in some cases of peripartum cardiomyopathy complicated by a subsequent pregnancy, the moral status of a normally functioning placenta, and the use of the principle of double effect in these cases. The signatories’ response sets out to demonstrate how Bringman and Shabanowitz do not engage the essential points of the statement of consensus and how their argument is premised on false assumptions. National Catholic Bioethics Quarterly 15.2 (Summer 2015): 241–250.

This essay is a response to an essay by Jay Bringman and Robert Shabanowitz titled “The Placenta as an Organ of the Fetus: A Response to the Statement of Consensus

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Deplantation of the Placenta in Maternal–Fetal Vital Conflicts

A Response to Bringman and Shabanowitz

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on Maternal–Fetal Conflict.”

The statement of consensuspertains to the medical issue of peripartum cardiomyopathy complicated by a subsequent pregnancy (PPCM+P) and includes clinical data, at its core the statement provides a moral evaluation and is a moral statement about treatment in cases of PPCM+P or analogous cases. To the extent that the statement provides a moral analysis, Bringman and Shabanowitz’s critique of it rests on three moral claims. The first claim is that pathologic cardiac tissue, and the per se threat it presents, is the exclusive morally relevant biological fact. The second is the claim that a normally functioning placenta is by definition morally precluded from being directly removed. The third claim is that the principle of double effect does not validly apply to early induction of labor for PPCM+P and is not analogous to its application in the case of a cancerous gravid uterus. Each of these moral claims depends on false assumptions that will be identified and analyzed here.

**Moral Status of the Pathological State**

**Threatening the Mother**

The statement authors make an important initial distinction by identifying two types of pathologic conditions and two corresponding types of danger. The two types of pathologic conditions and their corresponding dangers that they recognize are the following: (1a) the pathology of cardiac tissue that is peripartum cardiomyopathy...
(PPCM); (1b) the specific threat, risk, or danger of death to the mother as a direct result of PPCM; (2a) the pathologic condition that is increased blood volumes which arise from the interaction of the normal functioning of the placenta and the diseased heart in cases of PPCM+P (“the pathological interaction”); and (2b) the threat, risk, or danger of death to the mother as a direct result of the pathological interaction.

The statement authors recognize only one of each type as being morally relevant for some cases of PPCM+P: 2a and 2b. They argue that the morally relevant pathologic condition is not reducible to simply the weakened cardiac tissue and how it may be ameliorated. Rather, the interaction of the normally functioning placenta and the diseased heart is the primarily relevant biologic fact, and in any given case it is this specific pathologic condition—not necessarily PPCM in isolation—that may pose a morally relevant danger to the mother. In short, it is morally relevant to a woman with underlying PPCM that blood volumes are increasing. As will be shown, these are two factors that partially fulfill the principle of double effect for the moral justification of early induction of labor.

Bringman and Shabanowitz make the fundamental error of criticizing the statement on the basis of a pathologic condition and a danger that the statement itself does not address as morally relevant for the kind of case examined. That is, Bringman and Shabanowitz do not engage the merits of the specific pathologic condition and danger that the statement authors identify as morally relevant. They instead simply dismiss and avoid it with little discussion, focus their discussion instead on a straw-man version of what is morally relevant for the statement authors, or make criticisms on the basis of assumptions in need of proof. What the statement authors regard as the morally relevant pathologic condition, Bringman and Shabanowitz have wrongly reduced to PPCM. This is because they make the general assumption that morally relevant pathologies are restricted to diseased organs. However, the statement authors demonstrate that this is not the position of the Catholic moral tradition. As a result of their conflation, Bringman and Shabanowitz also wrongly reduce what the statement authors regard as the morally relevant danger in cases of PPCM+P to the danger from PPCM apart from the interaction with the placenta. Through their erroneous conflations, Bringman and Shabanowitz critique a position that does not correspond to the actual medical and moral claims of the statement. To show how Bringman and Shabanowitz do not engage what the statement regards as morally relevant, textual evidence needs to be presented.

The statement authors describe PPCM as a pathophysiologic process that “involves inflammation in the heart that damages cardiac cells, causing cellular death or scarring. Since scarred muscle tissue cannot contract efficiently, the heart’s ability to pump effectively decreases in proportion to any increase in scarred tissue. Consequently, the heart is unable to pump sufficient blood to meet the body’s needs.” The statement authors then distinguish PPCM from PPCM+P and go on in section 7 to point out that

4 Ibid., 479, n. 3.
although rare, PPCM+P presents a unique threat to the life of the mother, one that is not caused simply by the mother’s weakened heart. . . . Rather, in PPCM+P it is the interaction of a normal functioning placenta (as it produces hormones that increase sodium and fluid retention and blood volumes to support both the mother and the fetus through pregnancy) with the mother’s weakened heart that engenders the specific threat to her life and that of her pre-viable child. This specific threat is not present when the placenta-derived hormones are not present.5

The statement authors further distinguish PPCM from the specific threat of the interaction of the placenta with the diseased heart when they state in the same section that early induction of labor to produce placental deplantation “does not cure the mother’s weakened heart—there is no current cure for such organ damage—but it does eliminate the pathological state that is a specific threat to the life of the mother and the child that arises directly from the interaction of the placenta and the diseased heart in PPCM+P.”6 The statement authors clearly identify the pathological interaction of placenta and diseased heart as distinct from PPCM, and the danger that arises from this pathological interaction, when they say, “It is the pathological interaction of the normal functioning placenta with the mother’s weakened heart that gives rise to the specific threat to the mother’s life” and, later, “The threat arises not from a particular organ but from the interaction of healthy organs and non-healthy organs or from the normal functioning of an organ that exacerbates or causes the condition that threatens the lives of both the mother and the unborn child.”7 The specific

5 Ibid., 481–482, n. 7, emphasis added.
6 Ibid., 482, n. 7, original emphasis.
threating condition can be summarized as increasing blood volumes, which arise from placental activity, on a weakened heart.

In criticizing the claim made in the statement of consensus that deplantation of the placenta eliminates “the specific threat that arises from the presence of such hormones in a woman with peripartum cardiomyopathy,” Bringman and Shabanowitz ignore the fact that by “specific threat” the consensus authors are referring to the threat arising from the interaction of placental hormones with the diseased heart. Bringman and Shabanowitz instead focus on the pathologic tissue of the heart itself by pointing out that in many cases the pathology remains indefinitely. Moreover, Bringman and Shabanowitz cite the acknowledgment by the statement authors that the action of induction does not cure the heart, as if the heart condition itself and the curing of it are the morally exclusive or determinative factors, but this is an assumption that they do not independently prove. Bringman and Shabanowitz mistakenly assume that the pathological interaction of placenta and diseased heart is not morally relevant, and they likewise mistakenly assume that the danger from this interaction must be evaluated only according to actual deaths that occur in the future. For Bringman and Shabanowitz, the fact that “maternal deaths have been reported years following the last pregnancy” means that “while the interaction may indeed be ‘grave,’ there is no direct evidence to support that early termination mitigates the danger.”

This is a seriously flawed claim.

Bringman and Shabanowitz erroneously equate or confuse actual deaths that occur later with the actual danger of death in specific cases. The fact that most deaths occur later, following a pregnancy with PPCM+P, does not mean that there are no morally relevant grounds to conclude that in a given case the mother’s life is in grave danger during the pregnancy or that danger of death from PPCM+P is present only after an extended time following the pregnancy. Bringman and Shabanowitz wrongly assume that the meaning of the term “present” as it is used in the statement in the phrase “grave and present danger” is exhausted by a temporal meaning that is tied to actual deaths. Given such an assumption, Bringman and Shabanowitz conclude that since most deaths reported in the literature occurred only at a later time, following pregnancy, there is no basis for the statement authors to claim that danger exists at the time of a specific pregnancy. But this is to assume the very thing in need of proof, namely, that the morally relevant meaning of “danger” is defined relative to the time of actual death. However, “present” refers to the particular circumstances of a patient’s condition that exist at the time of the judgment to treat. Thus, while it may be true that some deaths occur an extended time after the pregnancy, this general fact in the aggregate does not negate the fact that the circumstances of a particular patient’s condition at the time of clinical judgment may be such that she is at risk of death from the pathological interaction.

To restrict the moral evaluation of danger retrospectively from the vantage of actual deaths that occur later is valid only if it is first assumed that danger cannot be morally assessed on the basis of the actual condition of the patient at the time of

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8 Bringman and Shabanowitz, “The Placenta as an Organ of the Fetus,” 34.
clinical judgment. The presence of shortness of breath, palpitations, and other signs of cardiac failure early in pregnancy are of great concern. Data suggest that exercise stress echocardiography to estimate left ventricular reserve may uncover subtle residual cardiac dysfunction that might be exacerbated during a pregnancy (a chemical stress test is often substituted in order to safely manage the test). In these cases, standard medical counseling includes the requirement that interruption of pregnancy be discussed and offered to the patient, and that most patients be counseled not to have any future pregnancies. Despite Bringman and Shabanowitz’s claim that they could not find a single instance in the literature of a patient dying during pregnancy, such documentation does exist. In fact, Whitehead et al. report that of 120 patients who died from PPCM within a year of giving birth, 48 percent died within forty-two days postpartum and 2 percent died during pregnancy. While this is admittedly a small percentage, it provides evidence that death during pregnancy from PPCM+P is a real possibility. Of note is a North Carolina quality study in which cardiomyopathy was cited as the leading cause of death during pregnancy and during the immediate postpartum period. Virtually all maternal deaths occur sometime after delivery. The point of early delivery is to avoid immediate maternal death by interrupting the additional cardiac burdens posed by the pregnancy. Delivery does not in and of itself prevent death at a later time from severe cardiac dysfunction. Instead, it allows for optimal maternal medical treatment that may enhance short-term survival, giving the mother the potential benefit of the only therapy that is curative or life saving for end-stage cardiac failure—that is, cardiac transplantation.

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10 In Catholic facilities, interruption of pregnancy cannot include direct abortion. Even though the standard of care may not respect the right to life of the fetus as aggressively as required by the Catholic moral tradition, it does legitimate the very real possibility that there can be a patient for whom continuation of the pregnancy would result in her death during the pregnancy itself and before viability.

11 Whitehead, Berg, and Chang, “Pregnancy-Related Mortality due to Cardiomyopathy,” 1328. See also Uri Elkayam, “Risk of Subsequent Pregnancy in Women with a History of Peripartum Cardiomyopathy,” *Journal of the American College of Cardiology* 64.15 (October 2014): 1631, citing Debasmita Mandal et al., “Pregnancy and Subsequent Pregnancy Outcomes in Peripartum Cardiomyopathy,” *Obstetrics and Gynaecology Research* 37.3 (March 2011): 226. Admittedly, Whitehead’s cases were from almost twenty years ago, but Mandal’s was not, and while in the Mandal case the death occurred during delivery and the patient was at twenty-seven weeks’ gestation, that is only a few weeks postviability, meaning the death easily could have occurred just a few weeks earlier, before viability.


13 Moreover, the fact that, in many of the most severe cases, patients choose to terminate the pregnancy means that fewer patients die from PPCM+P during pregnancy than
Not only do Bringman and Shabanowitz beg the question with respect to the meaning of “danger,” but their retrospective analysis of it is contrary to the conditions of moral certitude required for a specific judgment that early induction of labor is morally licit. As the statement authors explain, in matters of moral judgment about contingent human action, absolute certitude is not morally required.14 Rather, what is required is moral certitude, in which there is no reasonable fear of error or doubt even though the fact of the opposite remains possible. Moreover, attaining moral certitude does not require that the judgment be more probable than an opposing probable judgment. So long as the judgment is based on substantive probable reasons, and objections to the contrary may be readily answered, the fact that there is an opposing opinion for which more probability is claimed is not something that invalidates moral certitude.15 Importantly, a judgment of moral certitude must be based on the actual circumstances at the time of judgment, not on a retrospective assessment that is absent of or ignores consideration of the circumstances that exist in the specific case. The argument made by the statement authors fulfills all of these conditions of moral certitude.16

The Moral Status of a Normally Functioning Placenta in PPCM+P

Bringman and Shabanowitz’s argument in the section titled “The Healthy Placenta and Uterus” is based on several fundamental assumptions that are the very items in question. One assumption is that because the placenta functions normally in PPCM+P, it has nothing to do de facto with the diseased heart of the mother. This assumption ignores the fact of the pathological interaction. This interaction shows that normal organ function can make an integral contribution to a distinct pathologic condition in addition to the pathology of the diseased heart. Bringman and Shabanowitz’s a priori assumption that normal organ function cannot contribute to a new pathologic condition is simply another instance of their general assumption that morally relevant pathologies are restricted to diseased organs—an assumption that is contrary to the Catholic moral tradition, as expressed in particular in the magisterium of Pope Pius XII and the writings of Juan de Lugo, which we will further explain later.17 By erroneously assuming that the normality of an organ precludes it from contributing to a pathological state, Bringman and Shabanowitz commit the non sequitur

otherwise would be expected, because termination prevents the natural progression of the disease and obscures evidence that treatment in severe cases is ineffective. See Elkayam, “Risk of Subsequent Pregnancy,” 1633.


15 This is the traditional view of moral certitude known as probabilism, which has a long history of acceptance in the Catholic moral tradition.

16 Moreover, the lack of safe postponement referenced in directive 47 of the Ethical and Religious Directives for Catholic Health Care Services represents a concept of danger that is determined by reasonable medical prognostication based on valid clinical tests and assessment of the circumstances of the mother, which must be factored into a judgment of moral certitude about treatment.

17 Colloquium, “Medical Intervention,” 487, n. 20.
of concluding that “in every situation where there is a normally functioning placenta and uterus acting on any diseased maternal organ, there would exist an argument for allowing an abortion to save the life of the mother.” 18 However, this conclusion rests on the false assumption that an organ qua normal cannot under any circumstances contribute to a pathology; and contrary to Bringman and Shabanowitz, the statement authors do not claim that any action of a normal placenta on a diseased organ within a pregnancy creates a pathological state that is dangerous to the mother. In fact, the statement authors affirm that “most patients with a history of peripartum cardiomyopathy who become pregnant have sufficient cardiac reserve to handle the additional cardiac burdens posed by pregnancy and can be safely managed until fetal viability or even term.” 19 The statement authors are careful to specify circumstances in which prognosis is more likely to be worse—for example, in “patients with residual left ventricular dysfunction.” 20 In other words, they argue that the pathological interaction in rare specific cases causes identifiable changes that can be recognizable risk factors for death in those particular patients.

Bringman and Shabanowitz also argue that the common physical derivation of the placenta and other fetal cells from the embryo, and the placenta’s genetic identity with the embryo, are facts sufficient to establish that the placenta is an integral part of the fetus. But this is to assume that physical derivation and genetic identity are sufficient by themselves to establish the placenta as an integral part of the fetus. Assuming such sufficiency is the very thing in need of proof. In fact, it may be argued that while it is true that the placenta is physically derived from and genetically identical to the embryo and fetus, these facts are insufficient to prove that the placenta is an integral part of the fetus. 21 Thus, the normalcy of a placenta in PPCM+P does not preclude the placenta from being constitutive of a life-threatening pathology, nor does its derivation necessarily prove that deplantation of the placenta in a severe case of PPCM+P is a direct attack on a vital organ of the fetus that thus constitutes a direct attack on the fetus itself. That the placenta is in fact a vital organ of the fetus is more assumed by Bringman and Shabanowitz than demonstrated.

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18 Bringman and Shabanowitz, “The Placenta as an Organ of the Fetus,” 35.
19 Colloquium, “Medical Intervention,” 480, n. 5, emphasis added.
20 Ibid.
21 Bringman and Shabanowitz mention the conclusion by Becket Gremmels et al. that the placenta is a quasi-substance in symbiosis with mother and child. Gremmels et al., “The Metaphysical Status of the Placenta,” National Catholic Bioethics Quarterly 14.2 (Summer 2014): 295–333, referenced in Bringman and Shabanowitz, “The Placenta as an Organ of the Fetus,” 35 note 13. However, Bringman and Shabanowitz do not refer to the arguments offered by Gremmels et al. (304–305) that are specifically against claims such as those made by Bringman and Shabanowitz regarding physical derivation and genetic identity. The metaphysical status of the placenta was a point of disagreement among the colloquium participants and was not included as an essential component of the statement. All the signers agreed that the directly intended effect of early induction of labor for appropriate cases of PPCM+P was to detach the placenta by acting upon the mother in order to eliminate the threat caused by the pathological interaction, not to directly take the life of the fetus.
Application of the Principle of Double Effect

Bringman and Shabanowitz make several erroneous assumptions in their analysis of how the statement authors apply the principle of double effect. They also carry over their previous assumptions about the morally relevant pathologic condition and the moral status of the placenta to their treatment of the principle in this issue. Bringman and Shabanowitz claim that “in order for the consensus statement’s argument to be valid, one would have to be assured that the placenta would be removed first, leaving the fetus intact.” This claim confuses the timing of the bad effect relative to the good effect with the first condition of the principle that pertains to the moral object of the act under consideration. Not only is this an incorrect determination of the moral object, but the conflation also incorrectly accounts for the timing of effects as evaluated under the third condition of the principle.

The first condition is that the rationally chosen object of the act must be morally good in nature or at least not be intrinsically evil. The act of inducing labor is not intrinsically evil because it mirrors and augments the natural process of labor by which all the contents of the uterus are evacuated when the retention of those contents would be harmful to child or mother. The intelligibility of labor is not defined by the evacuation of one or another specific component of the in utero contents, but rather by the evacuation of all the contents including the placenta. Therefore, in any given case of early induction for the pathological interaction in PPCM+P, whether the death of the fetus occurs after the separation of the placenta from the uterus, together with and at the same time as the separation, or whether it occurs prior to the separation makes no difference to the moral object of the induction, because the death of the fetus is not the chosen object or the specific means used to eliminate the pathological interaction. In all three situations, the death of the fetus remains a foreseen but unintended and indirect bad effect of the act of induction of labor, whose nature is not intrinsically evil.

With respect to Bringman and Shabanowitz’s assumptions about the third condition of the principle, this condition allows the good and bad effects to occur concomitantly insofar as the bad effect is not the cause of the good effect. This means that the principle of double effect does not require a certain time sequence for the occurrence of the effects, as Bringman and Shabanowitz wrongly assume. Thus, the fact that the fetus may in any given case die at a time before the separation of the placenta from the uterus is complete does not make the death of the fetus a cause of the good effect, nor does it make the death of the fetus the moral object of induction. Whether the fetus dies before or after deplantation of the placenta, the placenta

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22 Bringman and Shabanowitz, “The Placenta as an Organ of the Fetus,” 36.
23 This use of the natural end of labor to explain the moral object of early induction of labor is not invalidated by problems of abnormal labor.
24 Some explanations of the principle mention this as a facile method of determining if an action meets the third criterion, but while this may indirectly help in some cases, the third condition itself centers on causality and not timing.
nevertheless separates as a direct result of induction of labor. Therefore, the death of the fetus is not the cause of the good effect in this case.

Bringman and Shabanowitz also argue that the statement’s use of the principle of double effect is not analogous to the justification of a hysterectomy for a cancerous gravid uterus, because the action in the case of a cancerous uterus is on a pathological organ. Contrary to Bringman and Shabanowitz, the two cases are, in fact, analogous, because they share the same analogon; namely, in both cases the ultimate end of the act is the elimination of grave risk or danger to the mother accomplished through means that are not defined by the death of the child. While it is true that the source of the danger in the case of the cancerous uterus is a diseased organ, removal of the organ is the means by which the ultimate end of eliminating the danger is achieved. Bringman and Shabanowitz again conflate the morally relevant danger with a diseased organ. Because the uterus is diseased in the case of a cancerous uterus, they assume that any application of the principle of the double effect to maternal–fetal vital conflict must involve a diseased organ as the only morally relevant pathology. However, since the ultimate end in both cases is the elimination of danger to the mother, the source of danger need not be restricted a priori to a diseased organ alone, given that the interaction of a normally functioning organism with a diseased organ is a legitimate source of danger. As noted earlier, this is precisely the point of the references to and explanation of the magisterium of Pope Pius XII and the work of Juan de Lugo in the treatment of “pathological condition” in the statement.

Questionable Assumptions

Bringman and Shabanowitz’s critique of the statement rests on the following assumptions: that the morally relevant pathologic condition and corresponding danger arise only from the cardiac condition of PPCM itself; that the statement applies to any case of PPCM or PPCM+P rather than to the rare cases in which moral certainty can be obtained that the mother would not survive to the time when the baby reaches viability; that the placenta is a vital part of the fetus and that a normal placenta cannot by definition be considered a part of a pathologic condition; and that the principle of double effect cannot validly apply to cases of the pathological interaction because of the possibility or likelihood of delayed separation of the placenta in early induction of labor and because induction in these cases is not analogous to treatment in cases of a cancerous gravid uterus. This response to Bringman and Shabanowitz has identified these assumptions, demonstrated that they need not be accepted, and argued that the assumptions prevent Bringman and Shabanowitz from successfully refuting the statement.

While the authors of the statement did not, as a group, agree to or make any claims about the metaphysical status of the placenta itself, they were in unanimous agreement that the act of deplantation removes a specific danger and threat to the life of the mother caused by the interaction of the placenta and the diseased heart. The statement authors were careful not to overstate their claims, but made it clear that a specific evaluation must be made based on reasonable prognostication, not simply on hypotheticals, to meet the standard of moral certitude regarding the specific threat or danger.